School Year 2018-2019
Before and After School Program
5010 Brown Station Road, #190
Upper Marlboro, Maryland 20772
240.510.3622

HOURS OF OPERATION:

SCHOOL DAYS ONLY:
Morning Program...6:30am Until Bus Arrival
Afternoon Program...Bus Drop-Off until 6:30pm

ENROLLMENT FORMS: All enrollment forms must be filled out completely and returned to our office before your child may begin the program. These forms include a registration/emergency form and health information. New forms must be filled out each year. You are responsible to notify the program immediately of any changes on this form.

SIGN IN/SIGN OUT: All children must be signed in and/or out by a parent/guardian or authorized person each day. Parents must come into the building to drop off or pick up their child. Please make sure staff is aware of your child's arrival and departure. No child can be released from the program to any other person other than his or her parent or a person currently designated in writing by such parent who is pre-authorized for pick up on the registration form. We must be notified in writing if another adult will be picking them up who is not listed. For safety purposes, photo identification will be required for all persons picking up children. We reserve the right to not allow any child to leave the building with anyone we believe to be under the influence of a substance, which would impair his or her ability to safely transport or care for a child.

ABSENTEE/ILLNESS: If your child is going to be absent, please call our office at 210.510.3622 as soon as possible. It is your responsibility to notify us if your child is going to be absent.

Your child's health is important to all of us. In order to keep our program a healthy place for children and staff, we must help prevent the spread of contagious illness. Please consider how you would feel if your child was exposed to other children who are ill when considering whether you should keep your ill child home or make alternate arrangements. When in doubt, please call us. Children cannot attend the program if they are ill or injured. They should be able to fully participate in the program. If your child becomes sick while at the program, you will be asked to pick him/her up immediately in order to prevent the spread of illness. Children should be free of an elevated temperature (100 or higher) at least 24 hours before returning to the program regardless of the reason. Following an illness, children should not return until they can resume normal activities. We may require a doctor's note before allowing a child to return to the program. This policy is not all-inclusive, and we reserve the right to send a child home for any health-related concerns.

INCLEMENT WEATHER/SCHOOL CLOSINGS: Our center will try our best to accommodate you during inclement weather and school closings. We will provide you with the information ahead of time. Additional fees may be charged for all day care.

PERSONAL ITEMS: Our staff will not be responsible for personal items brought to the program. Please label your child's items in case they are left behind. We reserve the rights to prohibit certain toys, electronics, etc., we feel are causing a disruption to the program. If you are concerned about your child's clothing, please send a smock for craft time. We cannot assume responsibility for damaged clothing.

MEDICATION: Limited to medication consent forms consistent with ADA such as Epi-Pen and rescue asthma medications (see program director). No child is allowed by State Law to carry medication on him/herself (i.e., Inhaler).

TRANSPORTATION: The Before and After School Program's responsibility begins when your child has reached the Before/After School Program site either via school bus or has been signed into the program. Our responsibility ends when your child boards the bus or is signed out by an authorized individual. Upon your child's enrollment into our Before and After School Program, it is your responsibility to contact the school district transportation office to arrange bus service for your child.

CLOSINGS: We follow the Federal Government closings as follows:

2018/19 Closings

Date	Federal Holiday	Day of the Week
September 3, 2018	Labor Day	Monday
November 12, 2018	Veterans Day (Observed)	Monday
November 22nd & 23rd, 2018	Thanksgiving	Thursday & Friday
December 25, 2018	Christmas Day	Tuesday
January 1, 2019	New Year's Day	Tuesday
January 21, 2019	Martin Luther King Day	Monday
May 27, 2019	Memorial Day	Monday
September 2, 2019	Labor Day	Monday
November 11, 2019	Veterans Day	Monday
November 28th & 29th, 2019	Thanksgiving	Thursday & Friday
December 25, 2019	Christmas Day	Wednesday

REGISTRATION INFORMATION

Our Before Care program begins at 6:30 a.m. The Barack Obama bus picks up at our location by 7:30a.m. If your child does not attend Barack Obama and is being dropped off at their designated school by our van service, they must be here no later than 7:30 a.m.

Our After-School program is from 2:00 p.m. to 6:00 p.m. There is a 30 minute grace period for pickup. After 6:30 p.m., there is a $5.00 late fee assessed for every 15 minutes late.

There is no additional fee for all day camp when schools are closed, i.e., teacher professional days or holidays. There are no refunds or adjustments for inclement weather, holidays or vacation.

Individual Student Enrollment: $50.00 Registration fee per child
Family Enrollment: $70.00

Please Check Appropriate Care Needed

□ AM ONLY - $45.00/Wk **A Security Deposit in the Amount of $45.00 is due at time of registration. This amount will be applied to the last week of the program.**
□ PM ONLY - $110.00/Wk **A Security Deposit in the Amount of $110.00 is due at time of registration. This amount will be applied to the last week of the program.**
□ AM & PM - $125.00/Wk **A Security Deposit in the Amount of $125.00 is due at time of registration. This amount will be applied to the last week of the program.**

NO CREDITS OR REFUNDS WILL BE GIVEN

We accept the following payment methods:
Money Order
Credit Card
Checks payable to: GirlFit Workout Studio.
No Cash Accepted On-Site

Payment is due the first day of the week…NO EXCEPTIONS
Payments are not prorated nor reduced based on your child attendance. _____(Please initial)
We require a 2-week written notice prior to withdrawing your child. _____(Please initial)

Non-payment of tuition is grounds for immediate dismissal from the program. Timely payments are essential for continued enrollment at KidFit Before & Aftercare Program; however, if you anticipate difficulty with paying on time, please discuss the matter with the Director immediately. If alternative arrangements for payment are approved you will be notified by the Director.

PLEASE WRITE "N/A" IF NOT APPLICABLE □ Child/Children Information (Same Family)

Name:	Gender:	Date of Birth:
School:	Grade:	
Name:	Gender:	Date of Birth:
School:	Grade:	

PARENT/LEGAL GUARDIAN INFORMATION

Mother's Name:	Father's Name:
Address:	Address:
Home/Cell:	Home/Cell:
Work:	Work:
Email:	Email:
Place of Employment	Place of Employment
Authorized to Pick Up Child: Yes or No	Authorized to Pick Up Child: Yes or No

Provide us with anyone you may give permission to pick up your child at any time or notify if parents cannot be reached:

Name	Address	Relationship	Phone #

HEALTH INFORMATION

MEDICATION POLICY: A parent or guardian will be called to pick up a child who is sick or injured. Medicine will not be administered without written permission from the parent or legal guardian.

PLEASE PROVIDE US WITH ANY MEDICAL INFORMATION PERTAINING TO YOUR CHILD WHICH WE SHOULD BE AWARE OF (food restrictions, activity restrictions, allergic reactions & special medications, special needs, disabilities, etc.)

_____

_____

_____

_____

EMERGENCY/MEDICAL INFORMATION

I, _____, parent/guardian of _____ (Date of birth)_____ do hereby give my permission and/or consent to the KidFit Before and After School Program to secure and authorize such emergency medical care and/or treatment as my child (above named) might require while under the supervision of said Before and After School Program staff. I also authorize said Before and After School Program staff to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay the entire costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

I understand every effort will be made to notify parents IMMEDIATELY in case of emergency.
Physician

Physician Name:	Phone#
Address:	

WAIVER/BEFORE AND AFTER SCHOOL AGREEMENT

Waiver/Policy must be read and signed before registration is accepted. I assume all risks and hazards incidental to the conduct of the above-mentioned program(s) and do hereby further release and hold harmless the KidFit Before and After School Program staff. I give permission to a licensed physician or hospital staff to administer emergency medical care deemed necessary for myself when normal permission is unavailable. I certify that my child or I are in good physical health and have no limitations other than those I have listed, which may predispose my child or I to risk during this program. I also fully realize that I must provide proper hospitalization. KidFit does not provide insurance coverage. I have read and understood the Refund Policy. Photo Release: I understand that photos may be taken of participants during the activity. These photos will become the property KidFit and may be used to promote the program. Before and After School Agreement: I have read the policies of the program and I agree to abide by such terms. The information on this form is accurate. I have provided all of the necessary information to properly care for my children.

Only person/s signing this form are authorized and responsible to make any change of information.

Parent/Guardian Signature:_____

Date: _____

Discipline Policy

Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, nonviolent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self-discipline. Based on this belief, GirlFit Aftercare Program uses a positive approach to discipline and practices the following discipline and behavior management techniques.

WE DO

- Communicate to children using positive statements.
- Communicate with children on their level.
- Talk with children in a calm quiet manner.
- Explain unacceptable behavior to children.
- Give attention to children for positive behavior.
- Praise and encourage the children.
- Reason with and set limits for the children.
- Apply rules consistently.
- Model appropriate behavior.
- Set up the classroom environment to prevent problems.
- Provide alternatives and redirect children to acceptable activity.
- Give children opportunities to make choices and solve problems.
- Help children talk out problems and think of solutions.
- Listen to children and respect the children's needs, desires and feelings.
- Provide appropriate words to help solve conflicts.
- Use storybooks and discussion to work through common conflicts.

WE DO NOT

- Inflict corporal punishment in any manner upon a child. (Corporal punishment is defined as the use of physical force to the body as a discipline measure. Physical force to the body includes, but is not limited to, spanking, hitting, shaking, biting, pinching, pushing, pulling, or slapping.)
- Use any strategy that hurts, shames, or belittles a child.
- Use any strategy that threatens, intimidates, or forces a child.
- Use food as a form of reward or punishment.
- Use or withhold physical activity as a punishment.
- Shame or punish a child if a bathroom accident occurs.
- Embarrass any child in front of others.
- Compare children.
- Place children in a locked and/or dark room.
- Leave any child alone, unattended or without supervision.
- Allow discipline of a child by other children.
- Criticize, make fun of, or otherwise belittle a child's parents, families, or ethnic groups.

Conferences will be scheduled with parents if particular disciplinary problems occur. If a child's behavior consistently endangers the safety of the children around him/her, then the Director has the right, after meeting with the parents and documenting behavior problems and interventions, to terminate child care services for that particular child.

My signature below indicates that I have received a copy of the discipline policy, it has been received by me, and I have read and understand this policy.

Signature_____ Date_____

Child_____

KidFit Before/After School Program
Financial Agreement

Child's Name _____ Age_____

Parent's Name_____

I _____, agree to the following payment policies, in order to have my child(ren) enrolled in KidFit Before/After School Program.

I agree to pay the weekly tuition fee $_____ and any other fees in full, every Monday, prior to leaving my child at the center. I understand that payment is due every Monday regardless if my child is ill or the center is closed. Furthermore, I understand that once tuition is paid there are no refunds and that payment should be made by check, money order, credit card or debit. If tuition is not paid on time (by close of business on Monday) a $5.00 late fee per day will be charged; and my child(ren) will be unable to return unless past due tuition and late charges are paid. Late fees also apply to debit card and credit card payments that are returned. KidFit Before/After School Program charges a $35.00 fee on all returned checks. Furthermore, the returned check and fees must be paid by money order, credit or debit by within 48 hours of notification. If two returned checks are accepted by the center, I understand the center will be unable to accept more of my personal checks.

I understand that the centers hours of operation are Monday through Friday 6:30am -6:30pm. Should I pick my child up after 6:30pm I agree to pay a late fee of $15.00 for each 15 minutes or fraction thereof after 6:30 in which my child remains at the center. I understand that late pick-up fees are due at the time I pick up my child(ren) or before returning to the center.

I agree to provide the center with a written two week notice of my intent to withdraw my child from the center and to pay all outstanding fees prior to dis-enrolling. I understand that my failure to do so could result in withholding or records and possible legal action if deemed necessary. Parents will be liable for all collection cost in addition to all outstanding fees, including 2 weeks charge if proper notice is not given.

I have read this financial agreement and agree to its term. Furthermore I understand failure to follow this agreement could result in the termination of childcare for my child(ren)

_____ _____

Parent/Guardian Signature Date

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE ____/____/____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until ____/____/____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- ***A physical examination*** *by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations****. A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at:* http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html *Select DHMH 896.*
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas****. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:* *http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf*

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select OCC 1216.

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Your Child's Routine Medical Care Provider	Your Child's Routine Dental Care Provider	Last Time Child Seen for
Name:	**Name:**	**Physical Exam:**
Address:	**Address:**	**Dental Care:**
Phone #	**Phone**	**Any Specialist :**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Feeding	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Counseling etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (Urinary Catheterization, G-Tube feeding, Transfer, etc.)

☐ No ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT
To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider **or** a computer generated immunization record must be provided. (This form may be obtained from: http://www.marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/forms.html Select DHMH 896.

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature: _____ Date: _____

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:

(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: ☐Yes ☐ No		

_____ **has had a complete physical examination and any concerns have been noted above.**

(Child's Name)

Additional Comments: _____

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

CHILDREN WHO ARE REQUIRED TO RECEIVE LEAD TESTING

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age.

If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.

The child's health care provider should record the test dates on page 3 of this form and certify them by signing and stamping the signature section of the form. All forms should be kept on file at the facility with the child's health records.

AT RISK AREAS BY ZIP CODE

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219

Baltimore (cont)
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781

Prince George's (cont)
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____ W:	C:	H:
		Place of Employment: _____ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

_____

ANNUAL UPDATES _____ _____ _____ _____
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Practitioner Date

_____ (_____)_____
Signature of Health Practitioner Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child's Picture (Optional)

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Non-prescription medication must be in the original container with the label intact.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

PRESCRIBER'S AUTHORIZATION

Child's Name:_____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name:_____ Dose:_____ Route: _____

Time/frequency of administration:_____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions:_____

Medication shall be administered from:_____ to_____
Month / Day / Year — Month / Day / Year (not to exceed 1 year)

Known Food or Drug: Allergies? Yes No If Yes, please explain_____

Prescriber's Name/Title: _____
(Type or print)

Telephone:_____ FAX: _____

Address: _____

Prescriber's Signature:_____ Date:_____
(Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature:_____ Date: _____

Home Phone #:_____ Cell Phone #:_____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature — Date

Parental approval: _____
Signature — Date

FACILITY RECEIPT AND REVIEW

Medication was received from:_____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form — Date